Washington State Department of Social & Health Services

CHILDREN'S ADMINISTRATION
MEDICAID TREATMENT CHILD CARE PROGRAM

STATEMENT OF MEDICAL NECESSITY

PLEASE PRINT CLEARLY

MTCC CONTRACTED PROVIDER:	MTCC SITE:		
MTCC ADDRESS:			
CONTACT PERSON:	PHONE:		
CHILD'S NAME:		DATE OF BIRTH:	AGE:
FIRST DATE OF CONTACT:	EPSDT DATE:		

ASSESSMENT DATES

PARENT CHILD OBSERVATION:	FAMILY ASSESSMENT:	CLINICIAN OBSERVATION:	CLINICIAN OBSERVATION:	CLINICIAN OBSERVATION:	DEVELOPMENT ASSESSMENT:

DIAGNOSIS AND TOOL USED TO DETERMINE THE ASSIGNED DIAGNOSES IS:

For children birth through 47 months:

DIAGNOSTIC CODE:	DIAGNOSTIC CLASSIFICATION AND DEVELOPEMNTAL DISORDERS OF INFANCY AND EARLY CHILDHOOD (DC:0-3) AXIS I OR AXIS II Child's Diagnoses, with current severity:
___ ___ ___	

For children 48 months and above (4years of age and older):

DIAGNOSTIC CODE:	DIAGNOSTIC AND STATISTICAL MANUAL (DSM IVR) AXIS I OR AXIS II Child's Diagnoses, with current severity:
___ ___ ___.___ ___	

CERTIFICATION AND SIGNATURES

By signing below, I certify all the information I have provided concerning this child is correct and accurately reflects Medicaid Treatment Child Care services are medically necessary to treat psychosocial disorders for this child.

LICENSED PRACTITIONER SIGNATURE:	DATE:
LICENSED PRACTITIONER PRINTED NAME:	LICENSED PRACTITIONER PRINTED TITLE: